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WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

100-101-24-33

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

AUG 11 1934

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

27418

1. PLACE OF DEATH

County.....

Registration District No. 791

Township.....

Primary Registration District No. 1003

City, St. Louis

(No.)

De Paul Hospital

File No.

Registered No. 7662

St.

Ward)

2. FULL NAME

(a) Residence No. 5535 Jennings Rd., St. L.P.

(Usual place of abode)

Ward. Jennings Mo.

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED, OR

Married

5A. IF MARRIED, WIDOWED, OR DIVORCED

HUSBAND OF

(OR) WIFE OF

Anna Kalemann (Tracie)

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

Aug 29, 1897

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1

day, hrs.

or min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

School Prop.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

Jennings Mo.

FATHER

13. NAME

Wm. Kalemann

14. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

Jennings Mo.

MOTHER

15. MAIDEN NAME

Mathilda Schumpe

16. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

St. Charles Mo.

17. INFORMANT

(ADDRESS)

Anna Kalemann

18. BURIAL, CREMATION, OR REMOVAL

PLACE

DATE

Calvary Cem. July 28, 1934

19. UNDERTAKER

(ADDRESS)

Math. Kalemann & Son

20. FILED

JUL 21 1934

J. A. Breckinridge

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR)

July 25, 1934

22. I HEREBY CERTIFY, That I attended deceased from

....., 19....., to....., 19.....

I last saw him..... alive on....., 19..... Death is said

to have occurred on the date stated above, at 10:00 p.m.

The principal cause of death and related causes of importance were as follows:

Date of onset

Other contributory causes of importance:

Name of operation

Date of

What test confirmed diagnosis?

Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide?

Date of injury....., 19.....

Where did injury occur?

(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed)

(Address)

